



APPLICATION FOR LICENSURE AS A HOME MEDICAL EQUIPMENT SERVICE PROVIDER

State Form 52525 (3-06)

Approved by State Board of Accounts, 2006

INDIANA BOARD OF PHARMACY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov

FOR OFFICE USE ONLY

Application fee	Date paid (month, day, year)	Receipt number
License number	Date of issue (month, day, year)	

DO NOT WRITE ABOVE THIS LINE

DOCUMENTATION

Attach copies of the following items to this application:

1. Medicare provider number _____ (verification letter)
2. Medicaid provider number _____ (verification letter)
3. Verification of each accreditation (if applicable)
4. Proof of insurance

BUSINESS INFORMATION

Legal name of business	
FEIN	Medicare identification (NSC) number
National Provider Identification (NPI) number (required after May 23, 2007)	Medicaid number

TYPE OF OWNERSHIP

- ☐ Sole proprietorship ☐ Limited liability corporation ☐ Other _____
- ☐ Partnership ☐ Corporation _____

ALL TRADE / BUSINESS NAMES USED BY THE ENTITY

FACILITY INFORMATION

Address of principal facility (number and street, city, state and ZIP code)		County
Telephone number ()	Fax number ()	
E-mail address	Website (if applicable)	
Principal mailing address (number and street, city, state and ZIP code)		County

FACILITY LICENSES / CREDENTIALS (ex: Pharmacy, FDA, CDL, etc.)

Type	Number	Date of expiration (month, day, year)
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OFF-SITE STORAGE FACILITIES

Number of off-site storage facilities or warehouses under the above listed ownership: _____
List the address of each facility (*attach additional sheets, if necessary*).

Address of facility (<i>number and street, city, state and ZIP code</i>)	County
Address of facility (<i>number and street, city, state and ZIP code</i>)	County
Address of facility (<i>number and street, city, state and ZIP code</i>)	County
Address of facility (<i>number and street, city, state and ZIP code</i>)	County

CONTACT PERSON (*Individual completing application*)

Name of contact person	Title
Telephone number ()	E-mail address

ACCREDITATION / CERTIFICATION (*Required for all Medicare providers after 01/01/07*)

Type	Date of expiration (<i>month, day, year</i>)
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SERVICES PROVIDED (*Check all that apply*)

- | | | |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Oxygen & oxygen delivery systems | <input type="checkbox"/> Low air loss cutaneous pressure management devices | <input type="checkbox"/> Nebulizers |
| <input type="checkbox"/> Ventilators | <input type="checkbox"/> Sequential compression devices | <input type="checkbox"/> Continuous Passive Motion (CPM) machines |
| <input type="checkbox"/> Respiratory disease management devices | <input type="checkbox"/> Feeding pumps | <input type="checkbox"/> Patient lift devices |
| <input type="checkbox"/> Continuous positive airway pressure (CPAP) devices | <input type="checkbox"/> Home phototherapy devices | <input type="checkbox"/> Defibrillators |
| <input type="checkbox"/> Electronic & computerized wheel chairs & seating systems | <input type="checkbox"/> Infusion delivery devices | <input type="checkbox"/> Other similar equipment as adopted by the Board: |
| <input type="checkbox"/> Manual wheelchairs | <input type="checkbox"/> Distribution | _____ |
| <input type="checkbox"/> Apnea monitors | <input type="checkbox"/> Distribution of medical gasses to end users for human consumption | _____ |
| <input type="checkbox"/> Transcutaneous electrical nerve stimulators | <input type="checkbox"/> Hospital beds & accessories | _____ |

If oxygen is checked above Do you transfill oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide FDA number.
If oxygen is checked above Do you carry over 1,000 pounds? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide DOT number.

QUESTIONS

1. Has the applicant, or any of the applicant's employees or associates ever been excluded from Medicare participation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has the applicant, or any of the applicant's employees or associates had a disciplinary action taken by the federal or state government of any license(s) held by any employee or associate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the applicant, or any of the applicant's employees or associates ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is any action pending on any of the above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

AFFIDAVIT

I do solemnly swear or affirm, under the penalties of perjury, that I am the person authorized to sign this application for licensure and that the statements made are true and correct in all respects.

Signature of contact person	Date signed (<i>month, day, year</i>)
Title of contact person	